Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1915	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	08/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE AND REHABILITATIO	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 848	1200-8-6-.08 (18) Building Standards (18) It shall be demonstrated through the submission of plans and specifications that in each nursing home a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observation and testing, it was determined the facility failed to maintain negative air pressure in a soiled area. The finding included: Observation and testing of clean laundry on 8/25/14 at 11:27 AM, revealed the clean side of the laundry had negative air pressure. The finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/25/14.	N 848 OK	The negative air pressure revealed in clean laundry Will be corrected by 9/30/14. The Plant Operations Director or designee will perform checks on all clean areas monthly times 3 months and correct immediately. These audits and corrections will be discussed in QA/PI beginning in September.	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SEP 02 2014
SEP 18 2014